Nursing Assistant Expired Registration Activation Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with application to:

Nursing Assistant Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

(This page intentionally left blank.)

Washington State Department of Health

Application Instructions Checklist

You will be notified in writing if further documentation is required.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay** Late Renewal Penalty Fee.
- ☐ **Pay** Current Renewal Fee.
- ☐ **Pay** Expired Registration Reissuance Fee.
  All fees are non-refundable. You can check the fee page for current fees.
- ☐ **1. Demographic Information.**

  Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

  Legal Name: List your full name.

  Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

  Birth date: Provide the month, day, and year of your birth.

  Birth place: Provide the city, state, and country where you were born.

  Address: List the address we should use to send any information on your registration. Be sure to include the city, state, zip code, county and country. This will be your permanent address with Department of Health until we have been notified of a change. See WAC 246-12-310.

  Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if applicable.

  Email: Enter your email address, if you have one.

  Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

- ☐ **2. Previous Credentialing.** List **all** licenses you have held since last being licensed in Washington State. List in chronological order, most current first. Include your last active license in Washington State. If you need more space, attach a piece of paper.

Application Instructions Checklist (Continued)

- ☐ **3. Professional Caregiving Experience.** In chronological order, list **all** your professional work experience since your Washington State credential expired. If you need more space, attach a piece of paper.
- ☐ **4. AIDS Education and Training Attestation.** Required by **WAC 246-12-040**.
- ☐ **5. Disciplinary Action Attestation.** Required by **WAC 246-12-040**.
- ☐ **6. Continuing Education Attestation.** Required by **WAC 246-12-040**.
- ☐ **7. Applicant's Attestation.** Required to be both signed and dated in order to process the application.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue IF 0299030000 00560

Nursing Assistant Expired Registration Activation Application

Please type or print clearly. Follow all instructions provided. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)	☐ Male ☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address (if different from above)

City	State	Zip	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

Registration # _____ Issue Date _____

Validation Date _____ Received _____

2. Previous Credentialing

State/ Jurisdiction	Profession	Location			Method of Credentialing	Currently in Force?	
		Type	Number	Year Issued		No	Yes

3. Professional Caregiving Experience

Type of experience of practice and location	Dates of Experience	
	Start (mm/yyyy)	End (mm/yyyy)

4. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. The education was through my professional education or through the completion of DSHS required training for caregivers or staff employed in DDD Certified Residential Programs. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested.

I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

Applicant's Initials

5. Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials

6. Continuing Education/Continuing Competency Attestation (if you have one)

I certify I have met all continuing and competency requirements for the past two years.
I am enclosing documentation on all classes attended/claimed.

Applicant's Initials

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ in _____
(mm/dd/yyyy) (City, State)

By: _____
(Signature of Applicant)

(This page intentionally left blank.)

Health Professions Reference Numbers and Links

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130

Administrative Procedure Act .....APA RCW 34.05

Administrative procedures and requirements..... WAC 246-12

Nursing Assistant Law ..... RCW 18.88

Nursing Assistant Rules..... WAC 246-841

Online

AIDS Training ..... Reference Page

Nursing Assistant Program.....Web page